

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04506

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>1 YEAR</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WYNELLE NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>REUBEN HAMILTON BAIR</b>		4. DATE OF DEATH Month Day Year <b>APRIL 14 1962</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 21 - 1888</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ACCOUNTANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PERFUME CO</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN E BAIR</b>		14. MOTHER'S MAIDEN NAME <b>CHARLOTTE GREEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-03-5794</b>	
17. INFORMANT Address <b>MRS CHARLES DIXON WOODSBORO MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral softening &amp; cortical atrophy</b> DUE TO <b>4-22-62</b> (b) <b>Cerebral thrombosis &amp; left hemiplegia</b> DUE TO <b>3 years</b> (c) <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>10 years</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 12, 1962</b> to <b>14 April 1962</b> that (I) (we) last saw the deceased alive on <b>13 April 1962</b> and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James E. Stoner Jr</b>		22b. DATE SIGNED <b>16 Apr 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES E. STONER, JR</b>		22d. ADDRESS <b>WALKERSVILLE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/17/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT HOPE</b>		23d. LOCATION (City, town, or county) (State) <b>WOODSBORO MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William E. Hartley</b>		25a. REC'D BY REGISTRAR DATE <b>APR 18 '62</b>	
ADDRESS <b>Woodsboro, Md</b>		25b. REGISTRAR'S SIGNATURE <b>William E. Hartley</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04510

04507

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. LENGTH OF STAY IN 1b <u>8 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK CITY HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>YADA THERESA BAKER</u>				4. DATE OF DEATH Month Day Year <u>APRIL 26 1962</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEBRUARY 10 1883</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>ROCKERSVILLE WASH. Co MD. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>OLIVER S. MULLENDORE</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE HORNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>JAMES A. BAKER</u> Address <u>NO. 9. N. VIRGINIA AVE. BRUNSVILLE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.1</u> DUE TO <u>Anger and by</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>2nd.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>4/18 1962</u> to <u>4/26 1962</u> that (I) (we) last saw the deceased alive on <u>26 April 1962</u> and that death occurred at <u>4:43</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert S. Hughes</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 29 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROCKERSVILLE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ROCKERSVILLE WASH. Co MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Bass</u> ADDRESS <u>BOONSBORO MD.</u>				25a. REC'D BY REGISTRAR <u>  </u> DATE <u>MAY 4 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04511 CERTIFICATE OF DEATH 04508

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN b. <b>13 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>EDGAR</b> Last <b>BARTHLOW</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 March 1882</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Detective Agency</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Lewistown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Barthlow</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Powell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-24-5679</b>	
17. INFORMANT <b>Prearranged by Deceased</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>Several years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1952</b> to <b>April 11, 1962</b> that (I) (we) last saw the deceased alive on <b>April 11, 1962</b> and that death occurred at <b>5:45 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Ernest A. Dettbarn</b> NAME (Type)		22b. DATE SIGNED <b>13 April 62</b>	
22c. PHYSICIAN'S NAME (Type) <b>ERNEST A. DETTBARN</b>		22d. ADDRESS <b>Walkerville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-14-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Feagaville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 16 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and in any event, within 72 hours after death, be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04509

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN TOWN Hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 50 Carver Apts		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Buckeystown d. STREET ADDRESS Buckeystown, Bx 62, Fred, Co e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Enis Virginia (Katie) BOWENS First Middle Last		4. DATE OF DEATH 4 22 19 62 Month Day Year	
5. SEX female	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-4-1892 9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Frederick, Co Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Richard Offutt		14. MOTHER'S MAIDEN NAME Lucy English	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Lola Bowens Hall		Address 115 Ice St, Frederick Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.0 DUE TO Ch Auricular Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arterio-sclerotic heart dis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9 Mar 1957, to 4/22/62, that (I) (we) last saw the deceased alive on 4 April 1962, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Conley Jr. M.D.		22b. DATE SIGNED 24 Apr 62	
22c. PHYSICIAN'S NAME (Type) Dr Charles H. Conley		22d. ADDRESS Professional Bldg, Frederick, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-27-62	
23c. NAME OF CEMETERY OR CREMATORY Hopehill		23d. LOCATION (City, town or county) Frederick Co (State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks, 111		ADDRESS Frederick, Md	
25a. REC'D BY REGISTRAR APR 30 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

1945-1

THE CASE OF

1945-1

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Items 18-21 Film 311												
MAYLAND STATE DEPARTMENT OF HEALTH												
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
04513 04510												
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick Life						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 20 West "n" Street						d. STREET ADDRESS 20 West "n" Street						
3. NAME OF DECEASED (Type or print) Robert Lewis Campbell Jr.						4. DATE OF DEATH 4-8-62 1962						
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-3-1929		9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Construction						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A?	
13. FATHER'S NAME Robert Lewis Campbell Sr.						14. MOTHER'S MAIDEN NAME Elsie Berry						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes						16. SOCIAL SECURITY NO.		17. INFORMANT Address Mary E. Campbell, Brunswick, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Ethyl Alcohol Intoxication 880.9 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 18 hrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Drinking early evening to about 4:30 AM												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. - 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Brunswick Frederick Md.		(County)		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE R. O. Thomas						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 4/8/62			
EXAMINER'S NAME (Type) R. O. Thomas						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) Frederick			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-62		22c. NAME OF CEMETERY OR CREMATORY Mountain		22d. LOCATION (City, town, or county) Knoxville, Maryland		(State)				
23. FUNERAL DIRECTOR B. H. Felt Brunswick, Maryland						24a. REC'D BY REGISTRAR DATE APR 12 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kram				

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*J. L. F.*

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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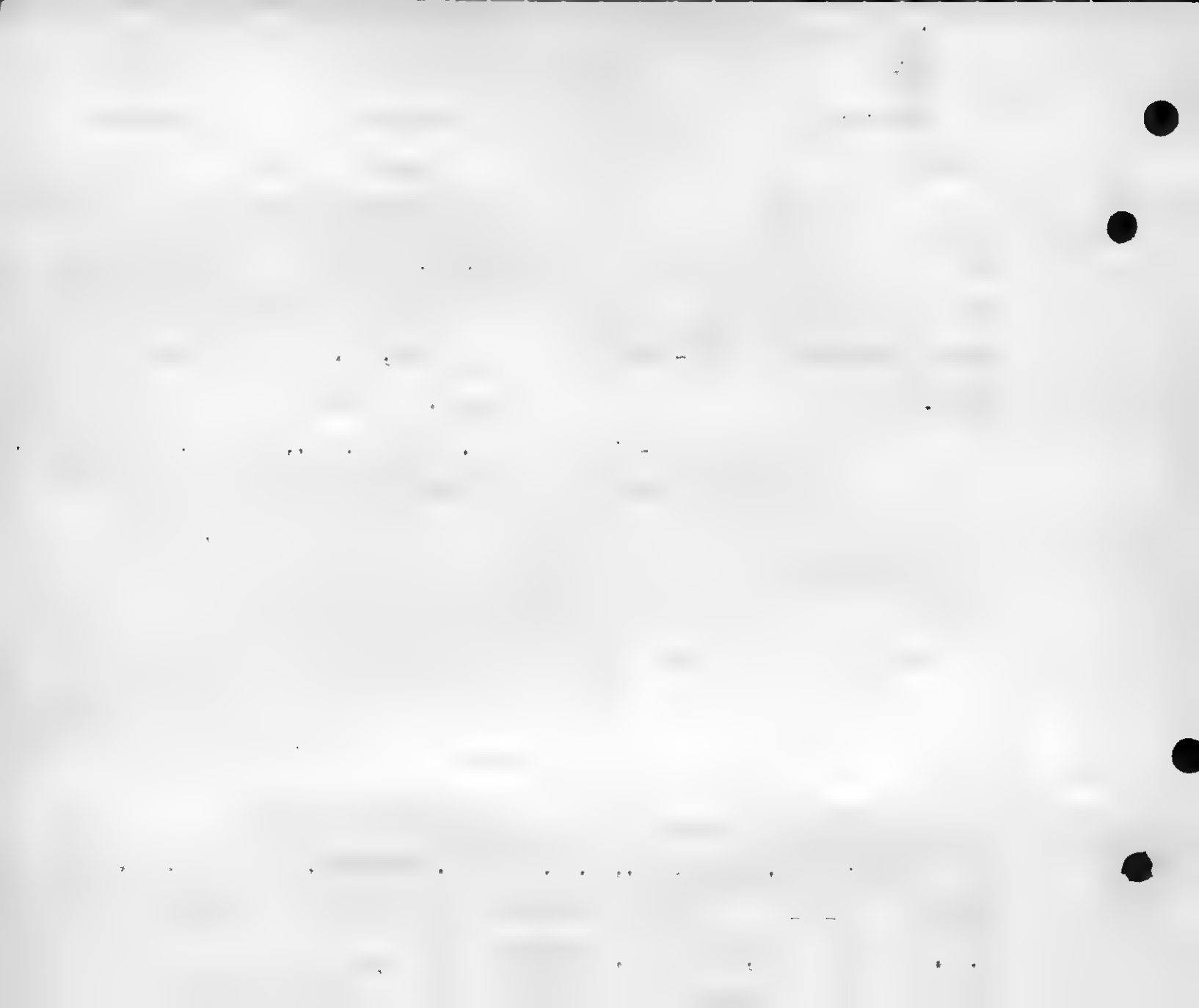
1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>111 West Fifth Street</b>		d. STREET ADDRESS <b>111 West Fifth Street</b>	
3. NAME OF DECEASED (Type or print) <b>WALTER AUGUSTUS CRAWFORD, SR.</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 Dec 1894</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>12</b> Hours <b>0</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Interior Decorator</b>		12. C. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>	
13. FATHER'S NAME <b>John R. Crawford</b>		14. MOTHER'S MAIDEN NAME <b>Mary C. O'Brien</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-5242</b>	
17. INFORMANT <b>Walter A. Crawford, Jr.,</b>		Address <b>Route 5, Frederick, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-genic Carcinoma rt. lung</b> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1962</b> to <b>April 4, 1962</b> that (I) (we) last saw the deceased alive on <b>April 20, 1962</b> and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Bernard O. Thomas, Jr.</b>		22b. DATE SIGNED <b>23 Apr 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Bernard O. Thomas, Jr., M. D.</b>		22d. ADDRESS <b>228 N. Market St., Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-25-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 25 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. H.</b>		25c. DATE	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. [redacted] may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

VR A15 (4)  
15M 9/60



1  
FOR STATE  
HEALTH DEPT.  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04515

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04512

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN b. <b>Fred'k.Co Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick, R.F.D.2 (Hopehill)</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Walter Franklin Diggs</b>		4. DATE OF DEATH <b>April 3 1962</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 23, 1899</b>	
9. AGE (In years, last birthday) <b>62</b>		10. IF UNDER 1 YEAR <b>Months Days Hours Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Frederick County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Luther Diggs</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-01-5863</b>	
17. INFORMANT <b>Emma N. Diggs</b>		Address <b>Hopehill Frederick Rt 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) <b>162-1</b> DUE TO <b>Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Brochogenic Carcinomoma Of Lung</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <b>162-1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hour</b> Year +	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. <b>DATE SIGNED April 5, 1962</b>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-7-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hopehill</b>		22d. LOCATION (City, town, or country) (State) <b>Hopehill, Fred. Co Md</b>	
23. FUNERAL DIRECTOR <b>C.E. Hicks, III</b>		ADDRESS <b>Frederick, Md</b>	
24a. REC'D BY REG. STRAR <b>APR 9 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22 Filed 4/25/62 mb

04517

## CERTIFICATE OF DEATH

Reg. Dist. No.

04514

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution on: Residence before admission) a. STATE <b>Conn.</b> b. COUNTY <b>Fairfield</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont, Maryland</b>		c. LENGTH OF STAY IN 1b <b>1 yr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WRGH, Ft Detrick, Maryland</b>		e. STREET ADDRESS <b>Old Norwalk Road</b>	
3. NAME OF DECEASED (Type or print) First <b>JONATHAN</b> Middle <b>NMI</b> Last <b>Ellsworth</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>28 May 1942</b>
9. AGE (In years last birthday) yrs. <b>19</b>		10. IF UNDER 1 YEAR: Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Marine</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Marine Corps</b>	
11. BIRTHPLACE (State or foreign country) <b>Norwalk, Conn</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas NMI Ellsworth</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>30 Sep 60-17 Apr 62</b>	
17. INFORMANT <b>Personnel Section</b> Address <b>Marine Hdqtrs. 8th &amp; I Street, Washington, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Wound, gunshot (suicide)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>976X</b> DUE TO (c) <b>976X</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Apparently from firing 45 cal. pistol</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>0530</b> <del>XXXX</del> <b>Apr 17 1962</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Bldg. 24 Post</b>	20f. (City or town) (County) (State) <b>Thurmont Frederick Md.</b>
21. I certify that I attended the deceased from <b>0530 17 Apr 1962</b> to <b>17 April 1962</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>0530 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John J. Dennehy</b> M.D.		ADDRESS (Street, city or town, state) <b>U.S. Army Medical Unit</b> DATE SIGNED <b>17 Apr 62</b>	
PHYSICIAN'S NAME (Type) <b>JOHN J. DENNEHY, Captain, MC</b>		<b>Fort Detrick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/19/62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Canaan, Connecticut</b>	22d. LOCATION (City, town, or county) (State) <b>New Canaan, Connecticut</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b>		24a. REC'D BY REGISTRAR <b>DATE APR 23 '62</b>	24b. REGISTRAR'S SIGNATURE <b>C. S. Evans</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04518

## CERTIFICATE OF DEATH

04515

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN TB <b>13 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b> d. STREET ADDRESS <b>E. Main St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margie</b> Middle <b>Agnes</b> Last <b>Finneyfrock</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 17, 1892</b>	
9. AGE (In years last birthday) <b>69</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	
11. IF UNDER 24 HRS Hours <b>1</b> Min. <b>1</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owr Home</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alonza Williar</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Wilhide</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Paul Finneyfrock</b>		Address <b>Thurmont, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Perforated Stomach</b> Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension</b> (a), stating the underlying cause last (c) <b>Chronic Bronchitis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>1 day</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. I certify that (I) (this hospital) attended the deceased from <b>12:00 p.m. 1962</b> to <b>1:00 p.m. 1962</b> , that (I) (we) last saw the deceased alive on <b>13th April 1962</b> , and that death occurred at <b>1:00 p.m.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Robert S. Hughes</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED <b>13 April 1962</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert S. Hughes</b> 7 E. Church St. Frederick, Maryland	
22d. ADDRESS <b>7 E. Church St. Frederick, Maryland</b>		23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>4-16-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>United Brethren Cemetery</b>	
23d. LOCATION (City, town or county) <b>Thurmont, Md.</b>		23e. (State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		25a. REC'D BY REGISTRAR <b>APR 16 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>		25c. DATE <b>APR 16 '62</b>	





CERTIFICATE OF DEATH

04516

1. PLACE OF DEATH  
a. COUNTY **Frederick** b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Frederick** c. LENGTH OF STAY IN b **5 days** d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Frederick Memorial Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE **Maryland** b. COUNTY **Frederick** c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Rural Myersville** d. STREET ADDRESS **1**

3. NAME OF DECEASED (Type or print) First Middle Last  
**Philip Israel Fisher**

4. DATE OF DEATH Month Day Year  
**4 18 1962**

5. SEX **male** 6. COLOR OR RACE **white** 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH **4/21/1886** 9. AGE (In years last birthday) **75** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **carpenter** 10b. KIND OF BUSINESS OR INDUSTRY **building const.** 11. BIRTHPLACE (County & State, or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME **George Fisher** 14. MOTHER'S MAIDEN NAME **Elmira Delauter**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **no** 16. SOCIAL SECURITY NO. **-** 17. INFORMANT Address **Daniel L. Fisher, Frederick, Md.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Gastric ulcer** DUE TO **gastric intestinal bleeding** (b) **2 1/2 Day** (c) **Jo.**  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **arteriosclerosis generalized**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **4/14/62** 19 **62** to **4/17/62**, that (I) (we) last saw the deceased alive on **4/18** 19 **62** and that death occurred at **1:45** A.M. from the causes and on the date stated above.

22a. SIGNATURE **Frank Damazo M.D.** 22b. DATE SIGNED **4/18/62**  
22c. PHYSICIAN'S NAME (Type) **DAMAZO FRANK** 22d. ADDRESS **7 W 3rd St Frederick**

23a. BURIAL, CREMATION, REMOVAL (Specify) **burial** 23b. DATE THEREOF **4/21/1962** 23c. NAME OF CEMETERY OR CREMATORY **Luth. Cem., Church Hill, Frederick Co., Md.** 23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE **Gladhill Company, Middletown, Md.** ADDRESS **1** 25a. REC'D BY REGISTRAR **APR 23 '62** 25b. REGISTRAR'S SIGNATURE **Wm. S. Kline**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04520

04517

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN b. <b>4 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson</b> d. STREET ADDRESS  e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <b>ANNIE CORDELIA FRY</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>28</b> Year <b>1962</b>		<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>3 Feb 1874</b>		<b>9. AGE</b> (In years last birthday) <b>88</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House-work</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Jefferson, Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>							
<b>13. FATHER'S NAME</b> <b>Joseph Rhoderick</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Cordelia Jane Boyer</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or (unknown) (If yes give year or dates of service)) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>				<b>17. INFORMANT</b> <b>Mrs. Eleanor M. Culler, 3018 Tilden St., N. W., Washington 8, D. C.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Acute myocardial infarction with acute pulmonary edema</b> 420.0 DUE TO (b) <b>Arterio-sclerotic heart dis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>Cholecystectomy 11 April 1962</b>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 hour</b> <b>Prior to 1957</b>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____				<b>20f. (City or town) (County) (State)</b> _____							
<b>21. I certify that (I) (this hospital) attended the deceased from... 1957... to... 28 April, 1962... that (I) (we) last saw the deceased alive on... 28 April, 1962... and that death occurred at... 10:35 P.M., from the causes and on the date stated above.</b>																			
<b>22a. SIGNATURE</b> <b>Charles H. Conley, Jr.</b>						<b>22b. DATE SIGNED</b> <b>30 Apr 1962</b>													
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Charles H. Conley, Jr., M. D.</b>						<b>22d. ADDRESS</b> <b>228 N. Market St., Frederick, Md.</b>													
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>5-1-62</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Paul's Cemetery</b>				<b>23d. LOCATION (City, town or county) (State)</b> <b>Jefferson, Md.</b>							
<b>24. FUNERAL DIRECTOR'S NAME AND ADDRESS</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>												<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAY 3 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kenna</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law further requires that the death certificate be signed by the attending physician and completed by the funeral director. The law further requires that the death certificate be signed by the attending physician and completed by the funeral director.

VR A15 (4)  
 15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director.

VR AIS (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thurmont rural	
c. LENGTH OF STAY IN b. 1 week		d. STREET ADDRESS Mountindale	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William R. Fultz		4. DATE OF DEATH April 28 1962	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 22, 1871	
9. AGE (In years) 90		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Fultz		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Sophia B. Fultz		Address Thurmont, Md. RD1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO CARDIO-RESPIRATORY COLLAPSE Conditions, if any, which gave rise to immediate cause (b) CONGESTIVE HEART FAILURE (a), stating the underlying cause last. (c) DUE TO ARTERIO-SCLEROTIC HEART DISEASE PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: INTRATROCHANTERIC FRACTURE RIGHT HIP 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 IMMEDIATE 8 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL AT HIS HOME	
20c. TIME OF INJURY Month, Day, Year 4/20/1962 Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL 20, 1962 to APRIL 28, 1962 that (I) (we) last saw the deceased alive on APRIL 28, 1962, and that death occurred at P.M. from the causes and on the date stated above.			
22a. SIGNATURE John H. Teske		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John H. Teske		22d. ADDRESS 4 W. Patrick St. Frederick, Md.	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 5-1-62	
23c. NAME OF CEMETERY OR CREMATORY Lewistown Cemetery		23d. LOCATION (City, town or county) Lewistown, Md. (State)	

24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager ADDRESS Thurmont, Md. 25a. REC'D BY REGISTRAR MAY 3 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04522

CERTIFICATE OF DEATH

Reg. Dist. No. 04519

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Thursant</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Corn</b> Middle <b>Miller</b> Last <b>Garrett</b>		4. DATE OF DEATH Month <b>4</b> Day <b>13</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-30-1874</b>
9. AGE (In years last birthday) yrs <b>87</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Barton Van Duren</b>		14. MOTHER'S MAIDEN NAME <b>Lidia Atkinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Miss Virginia Garrett, Thursant, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary heart failure</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12:00 p.m. 4-12-62</b> to <b>1:00 p.m. 4-12-62</b> , that I last saw the deceased alive on <b>4-12-62</b> , and that death occurred at <b>6:00 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Robert S. Hughes</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Robert S. Hughes</b>		<b>Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-16-62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Saint Marks</b>	22d. LOCATION (City, town, or county) (State) <b>Petersville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edwin E. ...</b>		ADDRESS <b>... ..</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 19 1962</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04523 CERTIFICATE OF DEATH 04520

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Myersville</b> c. LENGTH OF STAY IN b. <b>16 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Myersville</b> d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Florence J. Gaver</b>		4. DATE OF DEATH <b>4 24 1962</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/11/1895</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. FATHER'S NAME <b>William Jones</b>		12. MOTHER'S MAIDEN NAME <b>Mary Jane Ellis</b>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		14. SOCIAL SECURITY NO. <b>213-24-7801</b>	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1: Multiple Myeloma 2: Diabetes Mellitus</b>		16. INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>	
17a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
18a. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		18b. INJURY OCCURRED While at work Not While at work	
18c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		18d. (City or town) (County) (State)	
19. I certify that (I) <del>(XXXXXX)</del> attended the deceased from <b>Nov. 19 55</b> to <b>April 62</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>April 24 62</b> and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.			
20a. SIGNATURE <b>Leo J. Gaver</b>		20b. DATE SIGNED	
20c. PHYSICIAN'S NAME (Type) <b>Leo J. Gaver, M.D.</b>		20d. ADDRESS <b>Mallow Hill Ave., Baltimore 29, Md.</b>	
21a. BURIAL, CREMATION, 21b. DATE THEREOF REMOVAL (Specify) <b>burial 4/27/1962</b>		21c. NAME OF CEMETERY OR CREMATORY <b>U.B. Cemetery</b>	
21d. LOCATION (City, town or county) (State) <b>Myersville, Md.</b>		21e. REC'D BY REGISTRAR 21f. REGISTRAR'S SIGNATURE <b>APR 26 '62</b>	
22. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>		22. ADDRESS	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

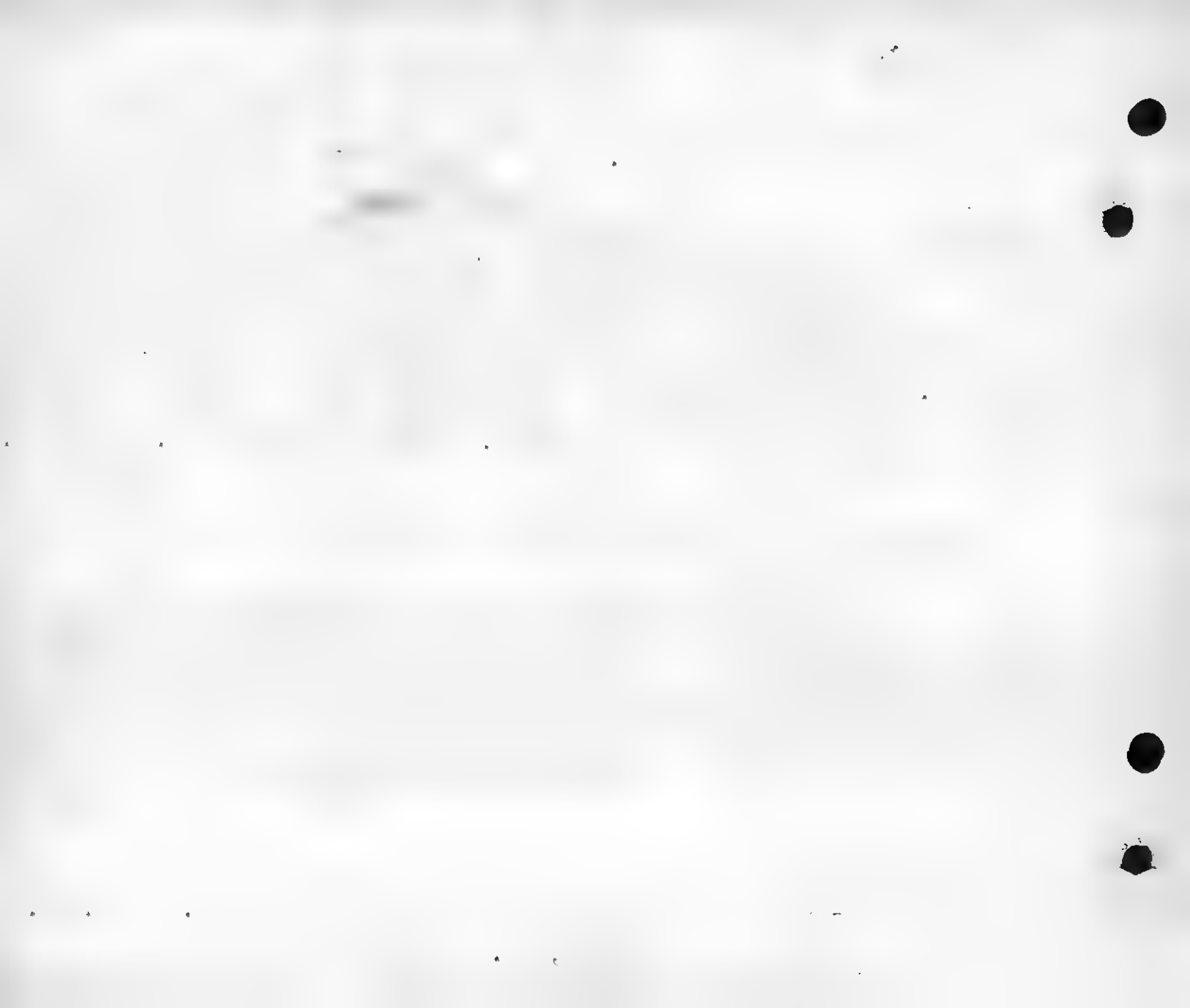
## CERTIFICATE OF DEATH

Reg. Dist. No.

04524

04521

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>			c. LENGTH OF STAY IN 1b <b>4 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mountaineale</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>104 7th Ave.</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Manzella</b> Middle <b>Virginia</b> Last <b>Gray</b>		4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>19 62</b>					
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13, 1871</b>	9. AGE (In years lost birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months <b>12</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eli D. Rice</b>			14. MOTHER'S MAIDEN NAME <b>Rosanna Rogers</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Earl M. Weddle Brunswick, Md. 104 7 Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>434</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Decompensated Congestive Heart Failure</b> DUE TO (c) <b>6 mon.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Gum Spring Hollow</b>	(County) <b>Brunswick</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Jan. 25</b> , 19 <b>62</b> , to <b>April 2</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>April 2</b> , 19 <b>62</b> , and that death occurred at <b>7:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Gum Spring Hollow</b> DATE SIGNED <b>April 2, 1962</b>							
ACTUAL SIGNATURE <b>C.T. Byron Kao</b>		PHYSICIAN'S NAME (Type) <b>C.T. Byron Kao, M.D.</b> <b>Brunswick, Maryland</b>					
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-5-62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lewistown Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lewistown Md. Fred. Co.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E Greager</b>			ADDRESS <b>Thurmont, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>APR 5 '62</b>	24b. REGISTRAR'S SIGNATURE <b>Carlton L. Hume</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04525

04522

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>FREDERICK</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL (LIMEKILN)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL (LIMEKILN)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RT # 2</b>		d. STREET ADDRESS <b>RT # 2</b>			
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>B</b> Last <b>GROVE</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>8</b> Year <b>1962</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1878 NOV. 8 1878</b>		
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>EDW. Bowles</b>		14. MOTHER'S MAIDEN NAME <b>MARY CHAGGETTE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>MRS FRANCIS Sappington</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 42000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b> <b>10 yrs +</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>6/20 1950</b> to <b>4/8 1962</b> that (I) (we) last saw the deceased alive on <b>4/8 1962</b> , and that death occurred at <b>6:15 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Henry V. Chase</b>		22b. DATE SIGNED <b>4/9/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>		22d. ADDRESS <b>4 E. Church St Frederick Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/11/62</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>		23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Clarence C. Gault</b>		24b. ADDRESS <b>Frederick Md</b>			
25a. REC'D BY REGISTRAR <b>DATE 7 16 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04526

### CERTIFICATE OF DEATH

04523

<b>1. PLACE OF DEATH</b> a. COUNTY <u>FREDERICK</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BRUNSWICK</u> c. LENGTH OF STAY IN 1b <u>30 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>EAST C. STREET</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BRUNSWICK</u> d. STREET ADDRESS <u>EAST C. STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>BERTHA C. HARRISON</u>		<b>4. DATE OF DEATH</b> <u>APRIL 20 1962</u>	
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>MARCH 12 1910</u>
<b>9. AGE</b> (In years last birthday) <u>52</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>1</u> Days <u>8</u> <b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>YARBROSBURG WASH. CO MD. U.S.A.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>ALONZA D. PHILLIPS</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>ANNIE HIMES</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u> <b>17. INFORMANT</b> <u>WILLIAM HARRISON BRUNSWICK MD</u> Address <u></u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> (b) <u>Arteriosclerotic Disease</u> (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 min.</u> <u>8 yrs.</u> <u>8 yrs.</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOT BY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u></u> e.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>April 19 1962</u> <b>to</b> <u>April 20 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>April 20 1962</u> <b>and that death occurred at</b> <u>4:15 p.m.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>C. T. Byron Kao</u> M.D.		<b>22b. ADDRESS</b> <u>Gum Spring Hollow, Brunswick, Md.</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>C. T. Byron Kao</u>		<b>22d. ADDRESS</b> <u>Gum Spring Hollow, Brunswick, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>APR 23 1962</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>BROWNSVILLE CEMETERY</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>BROWNSVILLE WASH. CO. MD</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John H. East</u>		<b>25a. REC'D BY REGISTRAR</b> <u>APR 25 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04524

04527

1. PLACE OF DEATH e. COUNTY <u>Frederick</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Mrs. Clara S. Hawkins</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 4, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Mills</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Algia Hawkins, Damascus, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u>Diabetic Gangrene of Feet</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e.g., 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY. Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/7</u> , 1962 to <u>4/20</u> , 1962, that (I) (we) last saw the deceased alive on <u>4/20</u> , 1962, and that death occurred at <u>1:15</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>A. A. Pearce</u>		22b. DATE SIGNED <u>4/20/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. A. Pearce</u>		22d. ADDRESS <u>4 E. Church St., Frederick, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<u>Burial</u>	<u>4/23/62</u>	<u>Monocacy</u>	<u>Beallsville Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest E. Fathner, Gaithersburg, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 24 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>William S. Thane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be completed by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.







TO HOSPITAL OR NURSING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b> c. LENGTH OF STAY IN b <b>6 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Own Home</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b> d. STREET ADDRESS <b>e. Main St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Cora</b> J. Middle <b>Lambert</b> Last <b>Lambert</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>4</b> Year <b>1962</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>March 16, 1870</b>
<b>9. AGE</b> (In years, month, day) <b>91</b> yrs		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>James H. Joy</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Rosanna Measell</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Mrs. Ross Firor</b> Address <b>Thurmont, Md.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart disease Arteriosclerotic type</b> DUE TO <b>720.0</b> Conditions, if any, which gave rise to immediate cause (b) <b>and</b> (c) <b>Terminal general exhaustion</b> DUE TO <b>Terminal general exhaustion</b> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>2 years</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <b>no</b>			
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>no</b> <b>19</b> Hour a.m. <b>no</b> p.m. <b>no</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>no</b> <b>20f. (City or town)</b> <b>no</b> <b>(County)</b> <b>no</b> <b>(State)</b> <b>no</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Nov. 19, 1961</b> <b>to</b> <b>Apr. 4, 1962</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Apr. 3, 1962</b> <b>and that death occurred at</b> <b>1962</b> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>James K. Gray</b>		<b>22b. DATE SIGNED</b> <b>Apr. 4, 1962</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>James K. Gray</b>		<b>22d. ADDRESS</b> <b>Thurmont, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4-7-62</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Middletown Refm. Cem.</b>		<b>23d. LOCATION</b> (City, town or county) <b>Middletown Fred. Co. Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Raymond B. Creager</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE APR 9 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>C. L. S. Thomas</b>			





TO HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04530

04527

<b>1. PLACE OF DEATH</b>												<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)											
a. COUNTY <b>Frederick</b>												a. STATE <b>md</b> b. COUNTY <b>Frederick</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>												c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>											
c. LENGTH OF STAY IN It <b>25 yrs</b>												d. STREET ADDRESS <b>Summit Ave</b>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Lewis Filling Sta. Main &amp; Church</b>												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <b>PAUL McCloskey LITTLE Jr.</b>												<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>21</b> Year <b>1962</b>											
<b>5. SEX</b> Male <b>6. COLOR OR RACE</b> White												<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
<b>8. DATE OF BIRTH</b> <b>Aug. 19-1917</b>												<b>9. AGE</b> (In years <b>44</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min)											
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Salesman</b>												<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Wholesale Grocery</b>											
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Pittsburgh Pa</b>												<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A</b>											
<b>13. FATHER'S NAME</b> <b>Paul M. Little Sr.</b>												<b>14. MOTHER'S MAIDEN NAME</b> <b>Agnes L. Tayman</b>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes W.W II</b>												<b>16. SOCIAL SECURITY NO.</b> <b>579-18-3394</b>											
<b>17. INFORMANT</b> <b>Paul Little III</b>												<b>Address</b> <b>Thurmont. md</b>											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic cardiovascular disease</b> (c) <b>5 years</b>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>122 hours</b>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)												<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part I of item 18.)											
<b>20c. TIME OF INJURY</b> Hour <b>19</b> s.m. p.m.												<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)												<b>20f. (City or town) (County) (State)</b>											
<b>21. I certify that (I) (this hospital) attended the deceased from 1957 to 1962, that (I) (we) last saw the deceased alive on 1962, and that death occurred at 1962, from the causes and on the date stated above.</b>																							
<b>22a. SIGNATURE</b> <b>Thomas A. Love</b>												<b>22b. DATE SIGNED</b> <b>4/23/62</b>											
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Thomas A. Love</b>												<b>22d. ADDRESS</b> <b>14 W. Main St. Thurmont md</b>											
<b>23a. BURIAL, CREMATION, REMOVA.</b> (Specify) <b>Burial</b>												<b>23b. DATE THEREOF</b> <b>4/24/62</b>											
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Carmel Cem.</b>												<b>23d. LOCATION</b> (City, town or county) (State) <b>Thurmont MD</b>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Raymond E. Crager</b>												<b>25a. REC'D BY REGISTRAR</b> <b>DATE APR 24 '62</b>											
<b>25b. REGISTRAR'S SIGNATURE</b> <b>William S. Thomas</b>																							



TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. The attending physician and the funeral director may sign the certificate. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04531  
04528

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>19 South Maple Avenue</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b> d. STREET ADDRESS <b>Petersville Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>Irene</b> Last <b>Mathews</b>				4. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-8-1886</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>22</b>		IF UNDER 24 HRS. Hours <b>19</b> Min. <b>62</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas E. Dean</b>				14. MOTHER'S MAIDEN NAME <b>Mary Oden</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Jessie Mathews, Brunswick, Maryland</b>			
17. INFORMANT <b>Mary Oden</b>				Address			
18. CAUSE OF DEATH [Enter only one cause primary for (a) (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aneurysm</b> 154 X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>154 X</b> DUE TO (c) <b>154 X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <b>None</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-20-62</b> to <b>4-22-62</b> that (I) (we) last saw the deceased alive on <b>4-22-62</b> and that death occurred at <b>4:10 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>C. E. PRUITT</b>				22b. DATE SIGNED <b>4-24-62</b>			
22c. PHYSICIAN'S NAME (Type) <b>C. E. PRUITT</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <b>BRUNSWICK, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-25-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Saint Lukes</b>		23d. LOCATION (City, town or county) (State) <b>Point of Rocks, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>B. H. Felt</b>				25a. REC'D BY REGISTRAR <b>APR 26 '62</b>		25b. REGISTRAR'S SIGNATURE <b>William L. Hanks</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b> d. STREET ADDRESS <b>208 "A" Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ida Louise Mathias</b>		4. DATE OF DEATH Month <b>4</b> Day <b>16</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-11-1877</b>
9. AGE (In years last birthday) <b>84</b> yrs		10. IF UNDER 1 YEAR: Months <b>4</b> Days <b>16</b> Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>-Sauers</b>		14. MOTHER'S MAIDEN NAME <b>Do not know</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>Polentus Mathias, Brunswick, Maryland</b>	
17. INFORMANT <b>Polentus Mathias, Brunswick, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Nephroses</b> (c), stating the underlying cause last. DUE TO <b>Congestive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 yr.</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 14, 1962</b> to <b>April 16, 1962</b> that (I) (we) last saw the deceased alive on <b>April 16, 1962</b> and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>C.T. Byron Kao, M.D.</b>		22b. DATE SIGNED <b>4-18-62</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Gum Spring Hollow, Brunswick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-19-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Louden Park</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>B. H. Fuld</b>		25a. REC'D BY REGISTRAR <b>APR 23 '62</b>	
ADDRESS <b>Brunswick, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be delayed after the hospital or attending physician has been signed by the attending physician and completed. Filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be completed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04533  
CERTIFICATE OF DEATH  
04530

<b>1. PLACE OF DEATH</b> a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 28 Carver Apt e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) Sarah Ann Moore First Middle Last		<b>4. DATE OF DEATH</b> April 6 1962 Month Day Year	
<b>5. SEX</b> Female	<b>6. COLOR OR RACE</b> negro	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 4-5-1891
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Domestic		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> *****	<b>11. BIRTHPLACE</b> (County & State, or foreign country) Frederick Co., Md
<b>13. FATHER'S NAME</b> Levin Leakins		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) no		<b>16. SOCIAL SECURITY NO.</b> none	
<b>17. INFORMANT</b> Address Frederick, Md 243 Center St Anna Mary Ambush			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PERNICIOUS ANEMIA - untreated, severe</u> DUE TO (b) <u>CEREBRAL THROMBOSIS</u> DUE TO (c) <u>12 hours</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 12 hours			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)	
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. 19	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (1) (this hospital) attended the deceased from 4/4 to 4/6, 1962, and that death occurred 4/6 AM, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> Richard C Reynolds <b>22c. PHYSICIAN'S NAME</b> (Type) Dr Richard C. Reynolds		<b>22b. ADDRESS</b> 9 E. Church Frederick, Md	<b>22b. DATE SIGNED</b> APR 9 '62
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial	<b>23b. DATE THEREOF</b> 4-9-62	<b>23c. NAME OF CEMETERY OR CREMATORY</b> Fairview	<b>23d. LOCATION</b> (City, town or county) (State) Frederick Md
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> C.E. Hicks, 111		<b>25a. REC'D BY REGISTRAR</b> APR 9 '62 <b>25b. REGISTRAR'S SIGNATURE</b> Arthur S. Hines	









TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. If the deceased was in the hospital or nursing home, the certificate may be completed by the attending physician and completed by the funeral director. If the deceased was at home, the certificate may be completed by the attending physician and completed by the funeral director. If the deceased was in a hospital or nursing home, the certificate may be completed by the attending physician and completed by the funeral director. If the deceased was at home, the certificate may be completed by the attending physician and completed by the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH

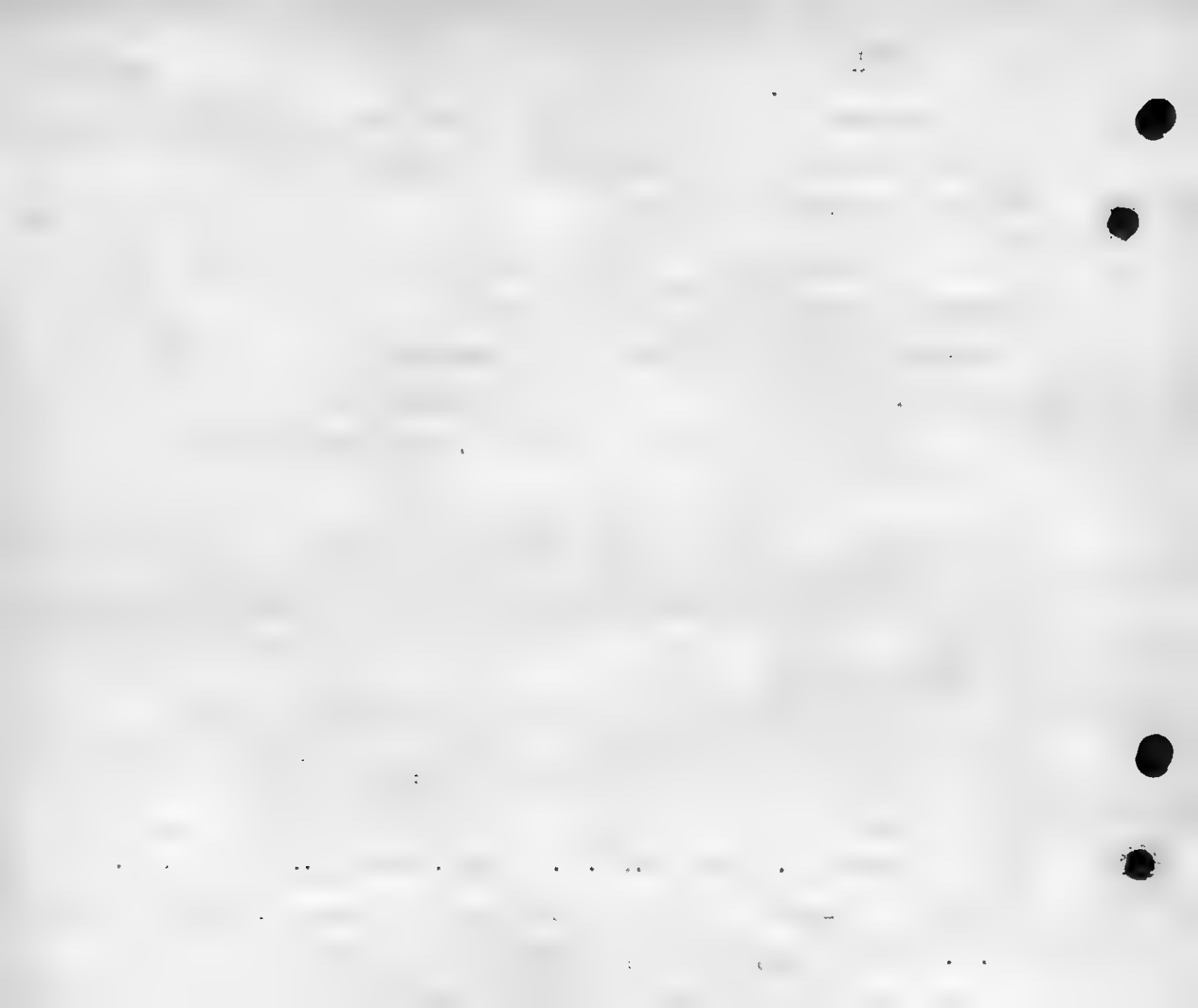
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04535

04532

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b> c. LENGTH OF STAY IN b. <b>Since 5/19/60</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Vindobona Convalescent &amp; Rest Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residency before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Buckeystown</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DAISIE ALICE RANNEBERGER</b>		4. DATE OF DEATH <b>April 18, 1962</b>	
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>4 Aug 1877</b>		9. AGE (In years IF UNDER 1 YEAR, IF UNDER 24 HRS. birth day) <b>84</b> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b> 11. BIRTHPLACE County & State, or foreign country <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles F. Oland</b>		14. MOTHER'S MAIDEN NAME <b>Clara Craver</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>Robert M. Ranneberger</b> Address (Same as item #2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senile Asthenia</b> DUE TO (b) <b>Generalized Arterio-sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>15 yrs</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1946</b> to <b>18 Apr 1962</b> , that (I) (we) last saw the deceased alive on <b>2 Apr 1962</b> , and that death occurred on <b>8:45 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles H. Conley, Jr.</b> M.D.		22b. DATE SIGNED <b>19 Apr 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Conley, Jr., M. D.</b>		22d. ADDRESS <b>228 N. Market St., Frederick, Md.</b>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <b>Burial 4-21-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	
23d. LOCATION (City, town or county) <b>Frederick, Maryland</b>		23e. REC'D BY REGISTRAR <b>APR 23 '62</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. If 4 months or more have elapsed since the death, the certificate must be signed by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04534

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>46 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>106 West Third Street</b>	
3. NAME OF DECEASED (Type or print) <b>SOPHIE JULIANNA REICH</b>		4. DATE OF DEATH <b>April 21, 1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>21 Feb 1885</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Registered Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Duty</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Frederick County Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaac S. Reich</b>		14. MOTHER'S MAIDEN NAME <b>Annie Zimmerman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Prearranged by deceased</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Bilateral hydronephrosis</b> DUE TO (c) <b>Left Pyonephrosis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Arterio-sclerotic Heart Dis. + Overexpansion Aortic Aorta</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days.</b> ? ?	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/21/62</b> 19 <b>51</b> , to <b>4/21/62</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>4/21/62</b> , and that death occurred at <b>1:50 P</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>23 Apr 1962</b>	
22a. SIGNATURE <b>Charles H. Conley, Jr.</b>		22c. PHYSICIAN'S NAME (Type) <b>Charles H. Conley, Jr., M. D.</b>	
22d. ADDRESS <b>228 N. Market St., Frederick, Maryland</b>		22e. REC'D BY REGISTRAR <b>APR 25 '62</b>	
22f. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>		22g. DATE	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-24-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25. REC'D BY REGISTRAR <b>APR 25 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>		25c. DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 4 may be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. Filled in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04537 CERTIFICATE OF DEATH 04533

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson-Rural</b> c. LENGTH OF STAY IN b. <b>32 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Near Jefferson</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson-Rural</b> d. STREET ADDRESS <b>Near Jefferson</b>	
3. NAME OF DECEASED (Also known as Frederick Nelson Ramsburg) (Type or print) <b>FREDERICK NELSON REMSBERG</b>		4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 June 1890</b>
9. AGE (In years last birthday) <b>71</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>71</b> Days <b>14</b> Hours <b>14</b> Min. <b>14</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Lewistown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Howard Remsberg</b>		14. MOTHER'S MAIDEN NAME <b>Mary Alice Rice</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-18-9595</b>	
17. INFORMANT <b>Mrs. Ida C. Remsberg (Same as item #1)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease with</b> <b>questionable acute myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2 weeks</b> DUE TO (b) <b>INTERVAL BETWEEN ONSET AND DEATH</b> DUE TO (c) <b>2 weeks</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-30-1962</b> to <b>4-14-1962</b> that (I) (we) last saw the deceased alive on <b>4-13-1962</b> and that death occurred at <b>3P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Rex R. Martin</b>		22b. DATE SIGNED <b>16 Apr 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Rex R. Martin, M. D.</b>		22d. ADDRESS <b>220 N. Market St., Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-18-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Lewistown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE</b>	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04538

04535

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u> c. LENGTH OF STAY IN TB <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>16 North Virginia Avenue</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u> d. STREET ADDRESS <u>16 North Virginia Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Clarence D. Shewbridge</u> f. SEX <u>Male</u> g. COLOR OR RACE <u>White</u> h. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> i. WIDOWED <input checked="" type="checkbox"/> j. DIVORCED <input type="checkbox"/> k. DATE OF BIRTH <u>8-18-1872</u> l. AGE (In years last birthday) <u>89</u> yrs.		<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>29</u> Year <u>1962</u> m. IF UNDER 1 YEAR: Months <u>4</u> Days <u>29</u> n. IF UNDER 24 HRS.: Hours <u>19</u> Min. <u>62</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Telegrapher U.S.O.R.R.C.</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>West Virginia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>James Shewbridge</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Wood</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>100-1-100000000</u> <b>17. INFORMANT</b> <u>Mrs. Geraldine Jones, Brunswick, Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive Heart Failure</u> 443X DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4/14</u> ..... 19 <u>62</u> to <u>4/29</u> ..... 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4/29</u> ..... 19 <u>62</u> and that death occurred at <u>10:50 a.m.</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>W. S. Carpenter</u> <b>22c. PHYSICIAN'S NAME</b> (Type) _____		<b>22b. DATE SIGNED</b> <u>4/21/62</u> <b>22d. ADDRESS</b> <u>Brunswick Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u> <b>23b. DATE THEREOF</b> <u>4-23-1962</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Harper</u> <b>23d. LOCATION</b> (City, town or county) <u>Harper's Ferry, West Virginia</u> (State) _____		<b>25a. REC'D BY REGISTRAR</b> DATE <u>APR 23 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be filed with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.







TO HOSPITAL OR AFTER DEATH. The law requires that the death certificate be executed within 24 hours after death. It may be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04540  
04537  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b> c. LENGTH OF STAY IN 1b <b>35</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>124 9th Avenue</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town, <b>Brunswick</b> d. STREET ADDRESS <b>124 9th Avenue</b> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Alma Lerona Smith</b>		4. DATE OF DEATH Month <b>4</b> Day <b>24</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years last birthday) <b>38</b> yrs IF UNDER 1 YEAR: Months <b>4</b> Days <b>24</b> IF UNDER 24 HRS.: Hours <b>19</b> Min. <b>62</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jashua Day</b>		14. MOTHER'S MAIDEN NAME <b>Laura Day</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>1-3</b>	
17. INFORMANT <b>Mrs. Lee Smith, Brunswick, Maryland</b>		Address <b>Brunswick, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b> <b>450.0</b> DUE TO (b) <b>450.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>450.0</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Brunswick</b> County <b>Frederick</b> (State) <b>Maryland</b>
21. I certify that (I) (this hospital) attended the deceased from <b>4/24/62</b> to <b>4/24/62</b> , that (I) (we) last saw the deceased alive on <b>4/24/62</b> and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J.G.F. Smith</b>		22b. DATE <b>4/26/62</b>	
22c. PHYSICIAN NAME (Type) <b>J.G.F. Smith</b>		22d. ADDRESS <b>Brunswick, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4-26-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Saint Marks</b>		23d. LOCATION (City, town or county) <b>Petersville, Maryland</b> (State) <b>Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>B. J. Felt</b>		25a. REC'D BY REGISTRAR <b>APR 30 '62</b> DATE	
ADDRESS <b>Brunswick, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

04541

04538

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>16 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>308 Adam Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>D.</b> Last <b>Snider</b>		4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 5-1926</b>
9. AGE (In years last birthday) <b>36</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clarence M. Snider</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Neal</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>196-14-3840</b>	
(If yes, give war or dates of service) <b>W War 11</b>		17. INFORMANT <b>Mrs. James D. Snider-308 Adam Rd.-Frederick-Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary atherosclerosis</b> (c) <b>1 1/2 yrs.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/16</b> 1961 to <b>4/27</b> 1962 that (I) (we) last saw the deceased alive on <b>4/27</b> 1962 and that death occurred at <b>M</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>L. R. Schoolman</b> M.D.		22b. DATE SIGNED <b>4/28/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. R. Schoolman</b>		22d. ADDRESS <b>810 Toll House Ave.-Frederick-Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-30-1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick- Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Dailey's Funeral Home-Frederick-Maryland</b> <i>by E. S. Dailey</i>		25a. REC'D BY REGISTRAR <b>MAY 1 '62</b>	
25b. REGISTRAR'S SIGNATURE <i>C. S. L. L.</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04542 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04539

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Vindabona Convalescent</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b> d. STREET ADDRESS <b>519 West Maple Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>John Chester Sneath</b>				4. DATE OF DEATH <b>4/18/62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-10-1898</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired helper B.F.O.R.R.Co</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Steven T. Sneath</b>				14. MOTHER'S MAIDEN NAME <b>Darcus C. LeGatz</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				17. INFORMANT <b>Mrs. Ollie Sneath, Brunswick, Md</b>			
16. SOCIAL SECURITY NO.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B.D. Thomas</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4-21-62</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>				22d. LOCATION (City, town, or country) <b>Frederick, Md</b> (State)			
23. FUNERAL DIRECTOR <b>A. H. Futo</b> ADDRESS <b>Brunswick, Maryland</b>				24a. REC'D BY REGISTRAR <b>APR 23 '62</b> DATE			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 74 hours of death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

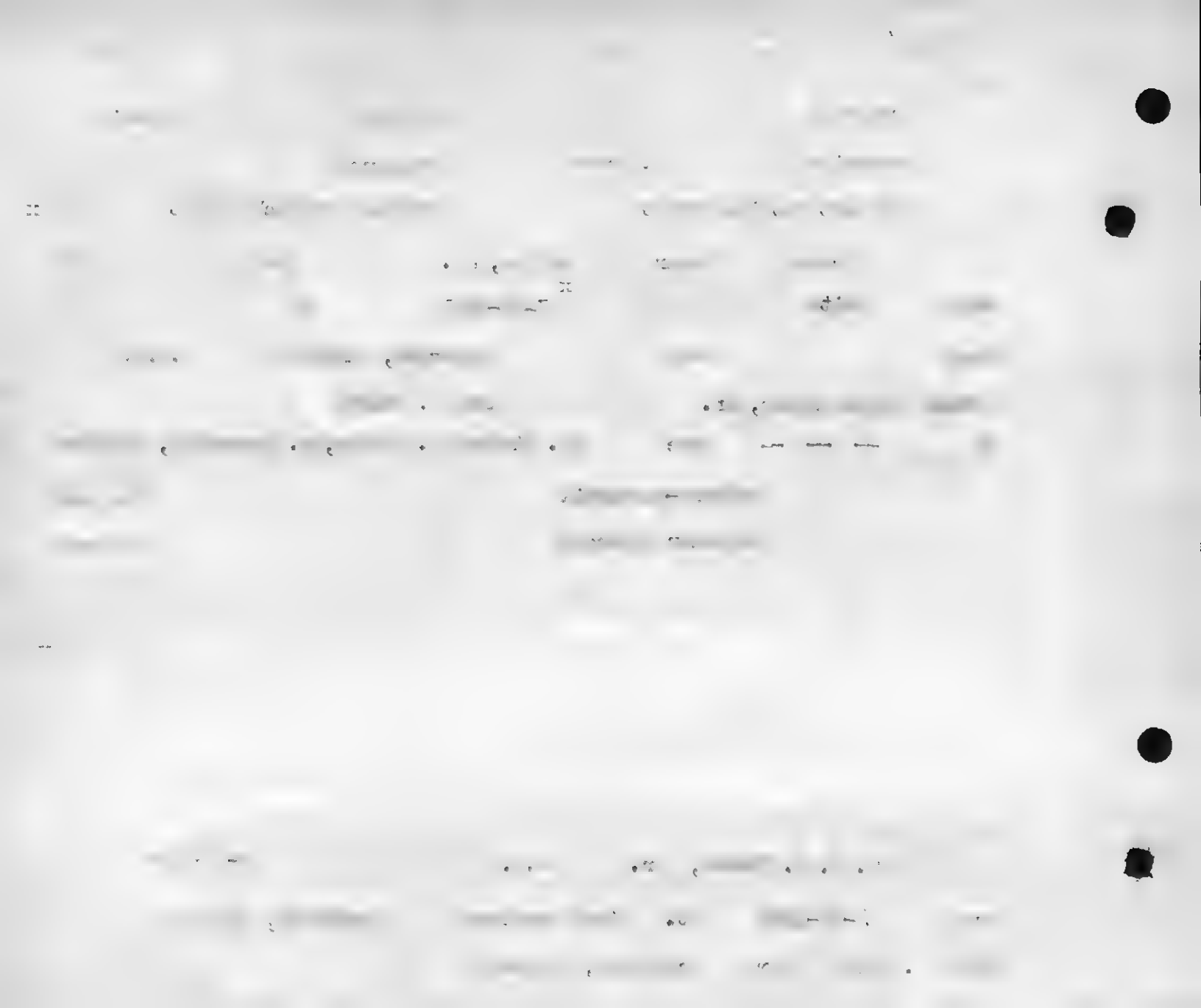
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Division of  
02543

**STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04540

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN IL <b>21 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>239 West Patrick Street</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Frederick</b> g. STREET ADDRESS <b>239 West Patrick Street</b> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Richard Edgar Snyder, Jr.</b> 4. DATE OF DEATH <b>April 16, 1962</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>3-15-1941</b> 9. AGE (In years last birthday) <b>21</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b> 11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Richard Edgar Snyder, Sr.</b> 14. MOTHER'S MAIDEN NAME <b>Anna L. Shafer</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>Mr. Richard E. Snyder, Sr.</b> Address <b>Frederick, Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> DUE TO (b) <b>Muscular Dystrophy</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: _____		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b> <b>21 years</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4-17-1962</b>		ACTUAL SIGNATURE <b>B. O. Thomas</b> EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas, Sr.</b> M.D. Address (Street, city, town, or county) <b>Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>4-19-1962</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b> ADDRESS <b>Frederick, Maryland</b>		22d. LOCATION (City, town, or country) (State) <b>Frederick, Maryland</b> 24a. REC'D BY REGISTRAR <b>4-18-62</b> 24b. REGISTRAR'S SIGNATURE <b>Robert E. Dailley &amp; Son</b>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04545  
04542  
MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>60 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Monocacy Hall Nursing</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>301 West Fifth Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CATHERINE PHILABENA STALEY</b>		4. DATE OF DEATH <b>April 4, 1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>16 Feb 1875</b>	
9. AGE (in years, last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours M'n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Frederick, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Conrad Brust</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Sandmyer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>220-30-4641A August T. Brust, Sr. (Same as item #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Chronic Congestive failure Arterio-sclerotic heart dis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 mos.</b> <b>10+ yrs.</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b> <b>10+ yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>15 Oct 1961</b> to <b>4/4/62</b> , 1962, that (I) (we) last saw the deceased alive on <b>2 April 1962</b> and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles M. Conley, Jr.</b>		22b. DATE SIGNED <b>4 Apr 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles M. Conley, Jr., M. D.</b>		22d. ADDRESS <b>228 N. Market St., Frederick, Md.</b>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <b>Burial 4-6-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	
23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 9 '62</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Smith</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04546

## CERTIFICATE OF DEATH

04543

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN TB <b>Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>267 Dill Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>EMMA GRACE STALEY</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>22</b> Year <b>1962</b>	
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>10 Sept 1892</b>	
<b>9. AGE</b> (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min. <b>69</b>		<b>10. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House-work</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home</b>	
<b>11. BIRTHPLACE</b> (County & State or foreign country) <b>Carroll County Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Charles W. Dorcus</b>		<b>14. MOTHER'S M A DEN NAME</b> <b>Emma Feiser</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>219-36-2605</b>	
<b>17. INFORMANT</b> <b>Irving E. Staley (Same as item #2)</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 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1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1080, 1081, 1082, 1083, 1084, 1085, 1086, 1087, 1088, 1089, 1090, 1091, 1092, 1093, 1094, 1095, 1096, 1097, 1098, 1099, 1100, 1101, 1102, 1103, 1104, 1105, 1106, 1107, 1108, 1109, 1110, 1111, 1112, 1113, 1114, 1115, 1116, 1117, 1118, 1119, 1120, 1121, 1122, 1123, 1124, 1125, 1126, 1127, 1128, 1129, 1130, 1131, 1132, 1133, 1134, 1135, 1136, 1137, 1138, 1139, 1140, 1141, 1142, 1143, 1144, 1145, 1146, 1147, 1148, 1149, 1150, 1151, 1152, 1153, 1154, 1155, 1156, 1157, 1158, 1159, 1160, 1161, 1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1200, 1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1300, 1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1400, 1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1410, 1411, 1412, 1413, 1414, 1415, 1416, 1417, 1418, 1419, 1420, 1421, 1422, 1423, 1424, 1425, 1426, 1427, 1428, 1429, 1430, 1431, 1432, 1433, 1434, 1435, 1436, 1437, 1438, 1439, 1440, 1441, 1442, 1443, 1444, 1445, 1446, 1447, 1448, 1449, 1450, 1451, 1452, 1453, 1454, 1455, 1456, 1457, 1458, 1459, 1460, 1461, 1462, 1463, 1464, 1465, 1466, 1467, 1468, 1469, 1470, 1471, 1472, 1473, 1474, 1475, 1476, 1477, 1478, 1479, 1480, 1481, 1482, 1483, 1484, 1485, 1486, 1487, 1488, 1489, 1490, 1491, 1492, 1493, 1494, 1495, 1496, 1497, 1498, 1499, 1500, 1501, 1502, 1503, 1504, 1505, 1506, 1507, 1508, 1509, 1510, 1511, 1512, 1513, 1514, 1515, 1516, 1517, 1518, 1519, 1520, 1521, 1522, 1523, 1524, 1525, 1526, 1527, 1528, 1529, 1530, 1531, 1532, 1533, 1534, 1535, 1536, 1537, 1538, 1539, 1540, 1541, 1542, 1543, 1544, 1545, 1546, 1547, 1548, 1549, 1550, 1551, 1552, 1553, 1554, 1555, 1556, 1557, 1558, 1559, 1560, 1561, 1562, 1563, 1564, 1565, 1566, 1567, 1568, 1569, 1570, 1571, 1572, 1573, 1574, 1575, 1576, 1577, 1578, 1579, 1580, 1581, 1582, 1583, 1584, 1585, 1586, 1587, 1588, 1589, 1590, 1591, 1592, 1593, 1594, 1595, 1596, 1597, 1598, 1599, 1600, 1601, 1602, 1603, 1604, 1605, 1606, 1607, 1608, 1609, 1610, 1611, 1612, 1613, 1614, 1615, 1616, 1617, 1618, 1619, 1620, 1621, 1622, 1623, 1624, 1625, 1626, 1627, 1628, 1629, 1630, 1631, 1632, 1633, 1634, 1635, 1636, 1637, 1638, 1639, 1640, 1641, 1642, 1643, 1644, 1645, 1646, 1647, 1648, 1649, 1650, 1651, 1652, 1653, 1654, 1655, 1656, 1657, 1658, 1659, 1660, 1661, 1662, 1663, 1664, 1665, 1666, 1667, 1668, 1669, 1670, 1671, 1672, 1673, 1674, 1675, 1676, 1677, 1678, 1679, 1680, 1681, 1682, 1683, 1684, 1685, 1686, 1687, 1688, 1689, 1690, 1691, 1692, 1693, 1694, 1695, 1696, 1697, 1698, 1699, 1700, 1701, 1702, 1703, 1704, 1705, 1706, 1707, 1708, 1709, 1710, 1711, 1712, 1713, 1714, 1715, 1716, 1717, 1718, 1719, 1720, 1721, 1722, 1723, 1724, 1725, 1726, 1727, 1728, 1729, 1730, 1731, 1732, 1733, 1734, 1735, 1736, 1737, 1738, 1739, 1740, 1741, 1742, 1743, 1744, 1745, 1746, 1747, 1748, 1749, 1750, 1751, 1752, 1753, 1754, 1755, 1756, 1757, 1758, 1759, 1760, 1761, 1762, 1763, 1764, 1765, 1766, 1767, 1768, 1769, 1770, 1771, 1772, 1773, 1774, 1775, 1776, 1777, 1778, 1779, 1780, 1781, 1782, 1783, 1784, 1785, 1786, 1787, 1788, 1789, 1790, 1791, 1792, 1793, 1794, 1795, 1796, 1797, 1798, 1799, 1800, 1801, 1802, 1803, 1804, 1805, 1806, 1807, 1808, 1809, 1810, 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, 1820, 1821, 1822, 1823, 1824, 1825, 1826, 1827, 1828, 1829, 1830, 1831, 1832, 1833, 1834, 1835, 1836, 1837, 1838, 1839, 1840, 1841, 1842, 1843, 1844, 1845, 1846, 1847, 1848, 1849, 1850, 1851, 1852, 1853, 1854, 1855, 1856, 1857, 1858, 1859, 1860, 1861, 1862, 1863, 1864, 1865, 1866, 1867, 1868, 1869, 1870, 1871, 1872, 1873, 1874, 1875, 1876, 1877, 1878, 1879, 1880, 1881, 1882, 1883, 1884, 1885, 1886, 1887, 1888, 1889, 1890, 1891, 1892, 1893, 1894, 1895, 1896, 1897, 1898, 1899, 1900, 1901, 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015,	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04547

04544

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN IC <b>Hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b> d. STREET ADDRESS <b>112 Maryland Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Edwin Ernst Stoffer</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>April 18 1962</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>January 9, 1889</b>	
<b>9. AGE</b> (In years last birthday) <b>73</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Theresa, Wisconsin.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Carl Stoffer</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>W.W.# 1</b>				<b>16. SOCIAL SECURITY NO.</b> <b>105-05-1318</b>			
<b>17. INFORMANT</b> <b>Jennie C. Stoffer, 112 Maryland Ave, Braddock, Md.</b>				Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>mesenteric artery occlusion with gangrene of small bowel 24 hrs.</b> (b) <b>570.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. p.m. <b>4/17</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>345</b> <b>20f. (City or town)</b> <b>Braddock</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>4/17</b> <b>to</b> <b>4/18</b> <b>1962</b> , that (I) (we) last saw the deceased alive on <b>4/18</b> <b>1962</b> , and that death occurred at <b>4:15</b> A.M. from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Frank Damazo</b> M.D.				<b>22b. DATE SIGNED</b> <b>4/18/62</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>DAMAZO FRANK</b>				<b>22d. ADDRESS</b> <b>7 W 3rd Frederick</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4/21/1962</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mount Olivet Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Frederick Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M.R. Etchison &amp; Son, Frederick, Maryland.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>APR 23 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>C. J. H. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04548

04545

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN b. <b>Minutes</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick - Rural</b> d. STREET ADDRESS <b>Nr. Adamstown</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>DOUGLAS Howard STUP</b>				<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>14</b> Year <b>19 62</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>January 3, 1960</b>	
<b>9. AGE</b> (In years last birthday) <b>2 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>2</b> Days <b>0</b>		<b>IF UNDER 24 HRS.</b> Hours <b>0</b> Min <b>0</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Infant</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (Country & State, or foreign country) <b>Frederick, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Howard J. Stup, Jr.</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Texanna Belle Wood</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Howard J. Stup, Jr. Route #4, Frederick, Maryland.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPHYXIA</b> (b) <b>ASPIRATION ESOPHAGEAL CONTENTS</b> (c) <b>TRACHEO-ESOPHAGEAL FISTULA - REPAIRED</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <b>2 mos.</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour <b>a.m.</b> <b>p.m.</b> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1960</b> <b>to</b> <b>14 April, 19 62</b> <b>that (I) (we) last saw the deceased alive on</b> <b>19</b> <b>and that death occurred at</b> <b>3 P.M.</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>F. J. HELDRICH</b>				<b>22b. DATE SIGNED</b> <b>14 April 62</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>F. J. HELDRICH</b>				<b>22d. ADDRESS</b> <b>FREDERICK, MD.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>April 17, 1962</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mount Olivet Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Frederick Maryland.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M.R. Etchison &amp; Son, Frederick, Maryland.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>APR 18 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04549 CERTIFICATE OF DEATH 04546

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Myersville</b> c. LENGTH OF STAY IN 1b <b>25 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Myersville</b> d. STREET ADDRESS <input checked="" type="checkbox"/> 15. RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MILTON V. SUMMERS</b> First Middle Last 4. DATE OF DEATH <b>April 5 1962</b> Month Day Year		5. SEX <b>male</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>Nov. 24, 1878</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <b>83</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>own Gen. Farm</b> 11. BIRTHPLACE (County, State, or foreign country) <b>Frederick Co. Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joshua Summers</b> 14. MOTHER'S MAIDEN NAME <b>Mary Leatherman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>no</b> (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <b>none</b> 17. INFORMANT <b>Mrs. Nannie Summers, Myersville, Md.</b> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Coronary Occlusion</b> <b>+ 20.1</b> DUE TO <b>Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>4-5-62</b> , that (I) (we) last saw the deceased alive on <b>4-5-62</b> , and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>D. J. Boyer</b> 22c. PHYSICIAN'S NAME (Type) <b>D. J. BOYER M.D.</b>		22b. DATE SIGNED <b>4-6-62</b> 22d. ADDRESS <b>135 No. Pot. St. HAG. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Apr. 7, 1962</b> 23c. NAME OF CEMETERY OR CREMATORY <b>United Brethern</b> 23d. LOCATION (City, town or county) (State) <b>Myersville, Fred. Co. Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b> ADDRESS <b>Myersville, Md.</b> 25a. REC'D BY REGISTRAR <b>APR 9 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be waived by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04550

04547

### 1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

Lifetime

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Monocacy Hall Nursing Home

### 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

d. STREET ADDRESS

100 East Third Street

a. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

### 3. NAME OF DECEASED (Type or print)

First

Ella

Middle

E.

Last

Urban

### 5. SEX

Female

### 6. COLOR OR RACE

White

### 7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

### 8. DATE OF BIRTH

Nov. 21-1884

### 4. DATE OF DEATH

Month

April

Day

11

Year

19 62

### 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

77 yrs.

### 10a. USUAL OCCUPATION (Give kind of work done during most of work, even if retired)

Retired Practical Nurse

### 10b. KIND OF BUSINESS OR INDUSTRY

Frederick Co. Md.

### 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

### 13. FATHER'S NAME

James Franklin Sherald

### 14. MOTHER'S MAIDEN NAME

Margaret Graser

### 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

217-12-1500

Mrs. Kathryn E. Grove-100 E. 3rd. St. Frederick Maryland

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

#### PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a)

Congestive Heart Failure

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

Arteriosclerotic Heart Disease

DUE TO

#### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).

Cerebral thrombosis with left hemiplegia

### 19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

### 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

### 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of 18)

### 20c. TIME OF INJURY Month, Day, Year

Hour a.m. p.m.

19

### 20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

### 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

### 20f. (City or town)

### (County)

### (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 24, 1962 to April 11, 1962 that (I) (we) last saw the deceased alive on Apr. 11, 1962 and that death occurred at 7:15 A.M. from the causes and on the date stated above.

### 22a. SIGNATURE

Henry V. Chase

M.D.

### ATTENDING PHYS.

### MED. DIRECTOR

### STAFF PHYS.

### 22b. DATE SIGNED

### 22c. PHYSICIAN'S NAME (Type)

Henry V. Chase

### 22d. ADDRESS

14 E. Church St. Frederick, Md.

### 23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

### 23b. DATE THEREOF

Apr. 11-1962

### 23c. NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cemetery

### 23d. LOCATION (City, town or county)

Frederick-Maryland

### 24. FUNERAL DIRECTOR'S SIGNATURE

Dailey's Funeral Home-Frederick-Maryland

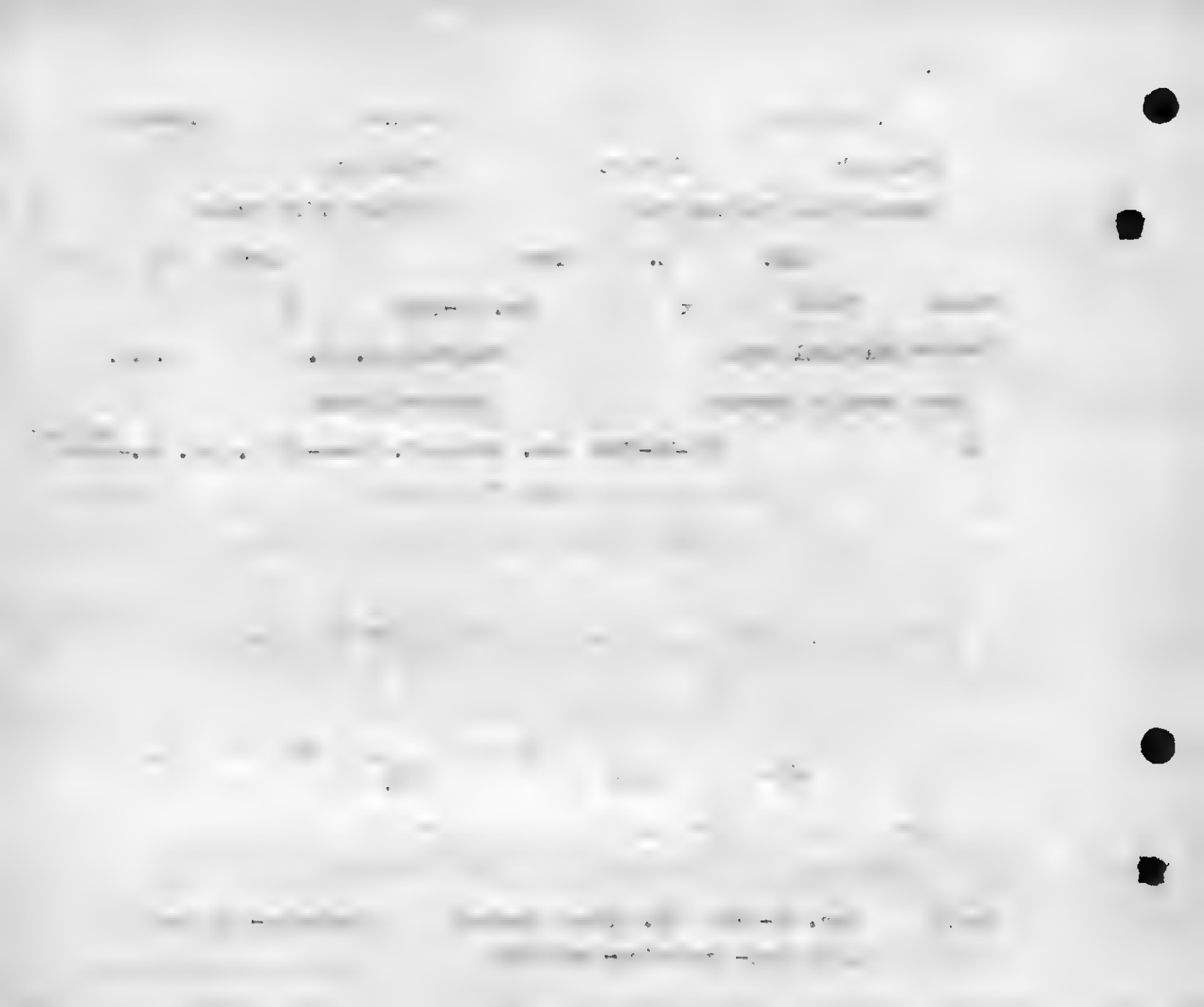
### ADDRESS

### 25a. REC'D BY REGISTRAR

### 25b. REGISTRAR'S SIGNATURE

DATE APR 16 '62

Arthur S. Francis



1  
FOR STATE  
HEALTH DEPT  
M  
X  
I  
C  
2  
P  
TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
04551					04548									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)									
a. COUNTY Frederick MARYLAND					a. STATE Maryland b. COUNTY Frederick									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (rural) Buckeystown 55 years					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (rural) Buckeystown									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt 4 Buckeystown, Fred, Co Md					d. STREET ADDRESS Rt 4 Buckeystown, Fred, Co. Md									
3. NAME OF DECEASED (Type or print) Dora Lottie Whimbs					4. DATE OF DEATH 4 23 19 62									
5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 5-4-1860					9. AGE (In years last b. rth day) 93 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY *****					11. BIRTHPLACE (State or foreign country) Maryland				
13. FATHER'S NAME Edward Bowie					14. MOTHER'S MAIDEN NAME Mary Spencer					12. CITIZEN OF WHAT COUNTRY? U.S.A				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. None					17. INFORMANT Mary W. Page Bolivar, West Va.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH 20 minutes				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42011 DUE TO Coronary Thrombosis														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arterio-Sclerosis										5 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
					20f. (City or town) Frederick, Co					(County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER				
ACTUAL SIGNATURE B.O. Thomas					ASSISTANT MEDICAL EXAMINER					DATE SIGNED 4-23-62 Fred, Md				
EXAMINER'S NAME (Type) B.O. Thomas					DEPUTY MEDICAL EXAMINER					Address (Street, city, town, or country) Professional Bldg				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 4-23-62					22c. NAME OF CEMETERY OR CREMATORY Carrollton Manor				
										22d. LOCATION (City, town, or country) Frederick, Co Md				
23. FUNERAL DIRECTOR C.E. Hicks, 111					ADDRESS Frederick, Md					24a. REC'D BY REG. STRAR APR 30 '62				
										24b. REGISTRAR'S SIGNATURE Arthur L. Thomas				



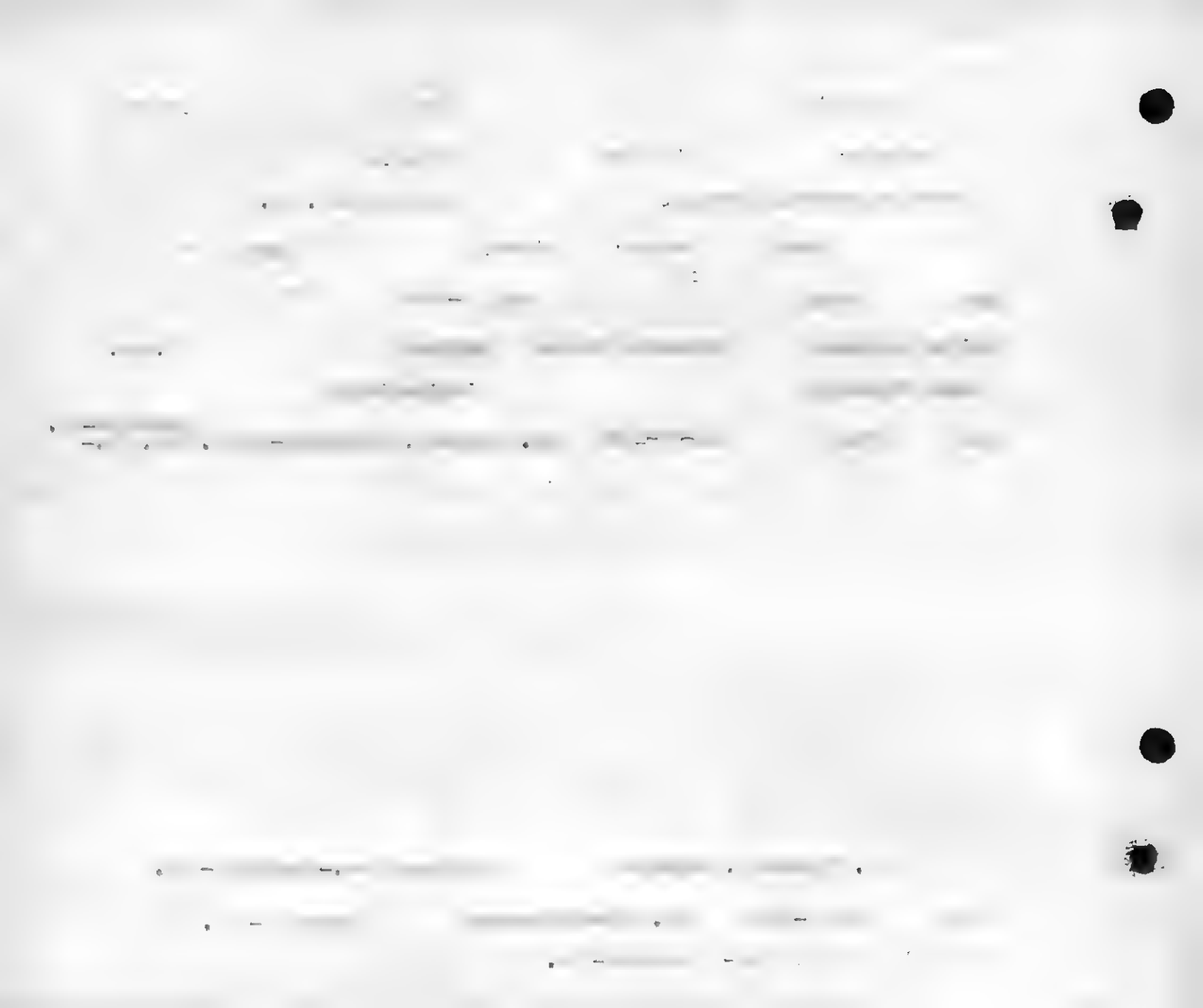
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, or attending physician, has been signed by the attending physician and completely filled out the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04552

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04549

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>404 West 2nd. St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Webster</b> Last <b>Whitehill</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9-1899</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min <b>62</b>	IF UNDER 24 HRS. Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min <b>62</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale tobacco</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Reese Whitehill</b>		14. MOTHER'S MAIDEN NAME <b>Norine Douty</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-10-1305</b>	
17. INFORMANT <b>Mrs. Irlene S. Whitehill-404 W. 2nd. St.-</b>		Address <b>Frederick-Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis, acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>8-10 yr.</b>		INTERVA. BETWEEN ONSET AND DEATH <b>7-8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/23</b> <b>1962</b> to <b>4/29</b> <b>1962</b> , that (I) (we) last saw the deceased alive on <b>4/29</b> <b>1962</b> and that death occurred at <b>9:00</b> <b>P.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard C. Reynolds</b>		22b. DATE SIGNED <b>3/1/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Richard C. Reynolds</b>		22d. ADDRESS <b>Toll House Ave.-Frederick-Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 2-1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick-Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Dailey's Funeral Home-Frederick-Md.</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 2 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04553

CERTIFICATE OF DEATH

04550

Item 9 Film 4312 5/1/62

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PEARL M. WHITLOCK</b>		4. DATE OF DEATH <b>4/22/62</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/7/91</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>Samuel L. Lingenfelter</b>		14. MOTHER'S MAIDEN NAME <b>Janie Tucker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		17. INFORMANT <b>Wm. E. Whitlock</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic Heart Disease</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Coronary Thrombosis with complete Left Bundle Branch Block</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 2, 1957</b> to <b>Apr. 12, 1962</b> that (I) (we) last saw the deceased alive on <b>4-22-1962</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Lester Lebo</b>		22b. DATE SIGNED <b>4/25/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>LESTER LEBOWITZ</b>		22d. ADDRESS <b>1801 Entaw Pl, Delton, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/27/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		23d. LOCATION (City, town or county) (State) <b>Howard Co Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Marjorie Don</b>		25. REC'D BY REGISTRAR <b>APR 27 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hana</b>			

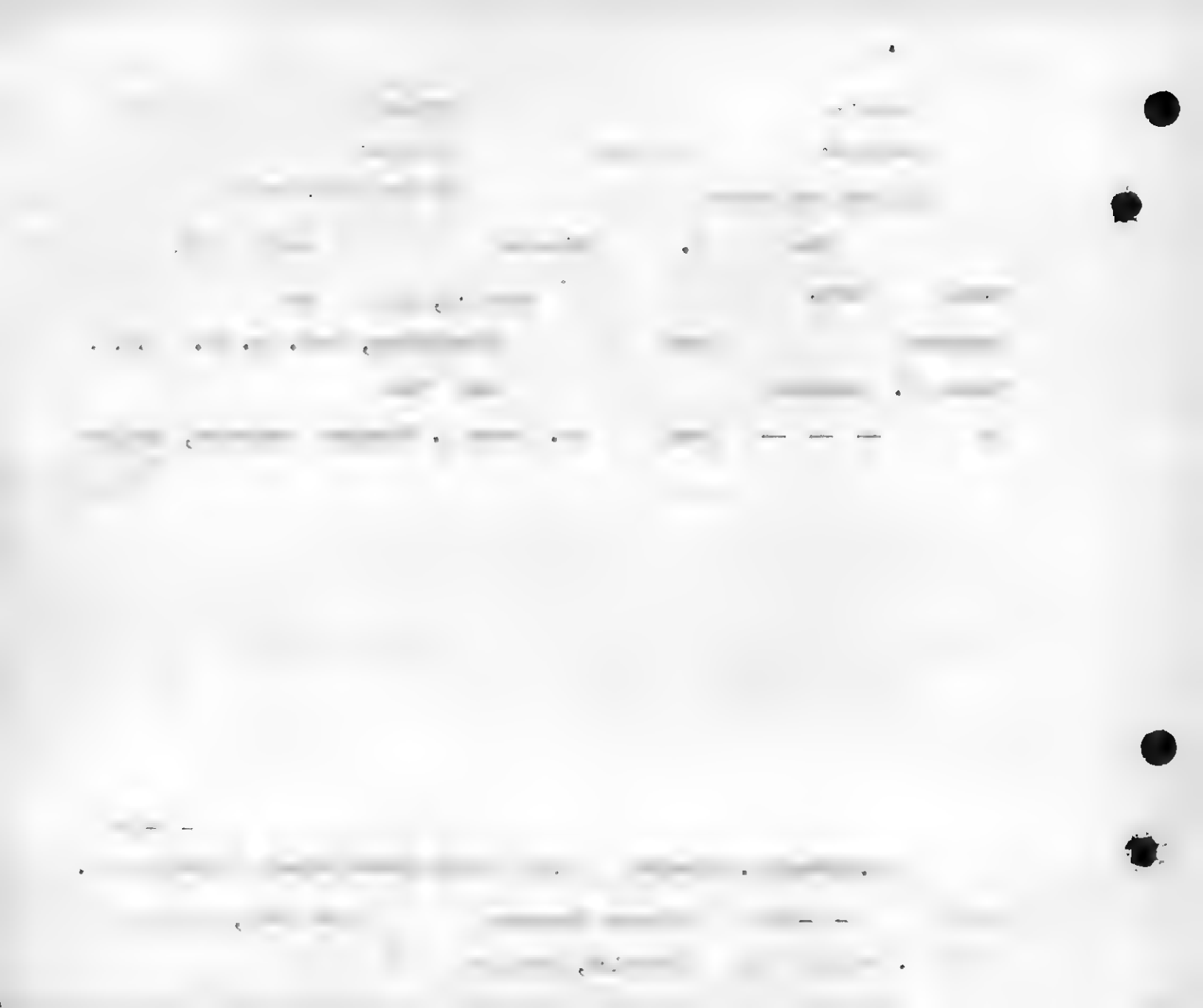




04551

MEDICAL CERTIFICATION

VR A15 (4)  
ISM 9/59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If not so executed, it may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04555

CERTIFICATE OF DEATH

04552

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN b. <b>Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>351 West Patrick Street</b>		2. USUAL RESIDENCE (Where deceased lived, if not put on residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>351 West Patrick Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RHODA CATHERINE YINGER</b>		4. DATE OF DEATH Month <b>April</b> , Day <b>4</b> , Year <b>1962</b>	
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>12 March 1872</b> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <b>90</b> IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b> 11. Bx. PLACE (County & State, or for foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Isiah Rice</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT (Address) <b>Mrs. Pauline Y. Boyer (Same as item #1)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>Angustic Heart Failure</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. <b>1 + 2</b> DUE TO <b>1 + 2</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1917</b> , to <b>Apr 4, 1962</b> , that (I) (we) last saw the deceased alive on <b>Apr 4, 1962</b> , and that death occurred at <b>10:20 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas E. Stone</b>		22b. DATE SIGNED <b>5 Apr 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas E. Stone, M. D.</b>		22d. ADDRESS <b>4 W. 3rd St., Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-7-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 9 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled out. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
04556 Item 2 Film G311 1/23/62 mb									
CERTIFICATE OF DEATH									
Reg. Dist. No. 04553									
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>			c. LENGTH OF STAY IN 1b <b>4 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown / Frederick</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Valley View Nursing Home</b>					d. STREET ADDRESS <b>RFD #5</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arba</b> Middle <b>Walter</b> Last <b>Younkins</b>					4. DATE OF DEATH Month <b>4</b> Day <b>12</b> Year <b>1962</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/7/1881</b>		9. AGE (In years last birthday) <b>80</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>building painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Martin L. Younkings</b>					14. MOTHER'S MAIDEN NAME <b>Caroline Koogle</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Nursing Home Records</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of urinary Bladder</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 10, 1962</b> to <b>April 12, 1962</b> , that I last saw the deceased alive on <b>April 10, 1962</b> , and that death occurred at <b>Middle town</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Middle town</b> DATE SIGNED <b>4-13-62</b>									
ACTUAL SIGNATURE <b>J. Elmer Harp</b> M.D.					PHYSICIAN'S NAME (Type) <b>Dr. J. Elmer Harp</b> <b>Maryland</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4/14/1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b> ADDRESS					24a. REC'D BY REGISTRAR DATE <b>APR 16 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		

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# CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>	
<p>2. Date of death: <u>Jan 15, 1950</u></p>	
<p>3. Place of death: <u>Home</u></p>	
<p>4. Cause of death: <u>Heart Disease</u></p>	
<p>5. Age at death: <u>65</u></p>	
<p>6. Sex: <u>Male</u></p>	
<p>7. Race: <u>White</u></p>	
<p>8. Marital status: <u>Married</u></p>	
<p>9. Occupation: <u>Teacher</u></p>	
<p>10. Signature of physician: <u>[Signature]</u></p>	
<p>11. Signature of registrar: <u>[Signature]</u></p>	
<p>12. Date of registration: <u>Jan 16, 1950</u></p>	
<p>13. Place of registration: <u>City Health Office</u></p>	
<p>14. Registrar's name: <u>John Smith</u></p>	
<p>15. Registrar's title: <u>Registrar</u></p>	
<p>16. Registrar's address: <u>123 Main St, City, State</u></p>	
<p>17. Registrar's phone: <u>123-4567</u></p>	
<p>18. Registrar's fax: <u>123-4567</u></p>	
<p>19. Registrar's email: <u>john.smith@cityhealth.gov</u></p>	
<p>20. Registrar's website: <u>www.cityhealth.gov</u></p>	

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## FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the date the certificate was written in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>Frederick</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>502 East Patrick Street</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>502 East Patrick Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>GLEN</b> Middle <b>JOSHUA</b> Last <b>ZIMMERMAN</b>						4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>19 62</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>14 July 1891</b>		9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Candy Store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Franklin Zimmerman</b>						14. MOTHER'S MAIDEN NAME <b>Mary J. Stone</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>217-10-0635</b>		17. INFORMANT Address <b>Mrs. Lorraine W. Zimmerman (Same as item #1)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>331X</b> (b) <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>5 Yrs-Plus</b>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>B. O. Thomas</b> EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>30 Apr 1962</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>5-2-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>			22d. LOCATION (City, town, or country) (State) <b>Frederick, Maryland</b>		
23. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>						24a. REC'D BY REGISTRAR <b>MAY 3 '62</b>			24b. REGISTRAR'S SIGNATURE <b>Orin L. Thomas</b>		

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RESEARCH AND DEVELOPMENT

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